Consumer Hotline: 1-800-282-8611

RESOLVING HEALTH CARE INSURANCE DISPUTES
An Action Kit for Delawareans

Most health care insurers doing business in Delaware operate in a reputable fashion. Yet, the Delaware Insurance Department handles many cases every year in which there are improper or questionable claim denials, slow payments and payment-related problems. While unable to force insurers to provide coverage that they are not legally obligated to provide, the Insurance Department is able to intervene in many cases.

Whether you are shopping for insurance or looking for assistance from the Insurance Department in resolving a conflict with your insurance company or agent, this guide will help you understand your rights and responsibilities as a policyholder and where to turn for help.

Understanding Types of Health Insurance

Each year, fewer and fewer Delawareans and Americans around the country are covered under traditional fee-for-service health insurance plans in which insured individuals go to a doctor of their choosing and then submit health insurance claims. Today, more and more people are covered by managed care plans. In an effort to control costs and to make them more affordable, managed care plans are more structured and restrictive than fee-for-service plans.

Managed Care comes in many different arrangements. The most prevalent are: Health Maintenance Organizations, Preferred Provider Organizations, and Point of Service Plans.

- **Health Maintenance Organization** (HMO). An HMO provides health services through a network of doctors, hospitals, laboratories, etc. The health care providers may either be HMO employees or have some other contract arrangement with the HMO. HMO plans pay providers a monthly set amount (a capitation fee) regardless of the amount of services performed. When you enroll in an HMO, you choose one of the doctors as your primary care physician (PCP) to manage all of your health care. Whenever you need health care, you first consult your primary care physician. Your PCP may refer you to an HMO-approved specialist.

- **Preferred Provider Organization** (PPO). A PPO is a group of doctors, hospitals, and other health care providers (preferred providers) who have agreed to provide services to members of a health plan for discounted fees. Some employers combine the PPO with a traditional major medical plan to allow you to use providers who are not on the PPO's preferred list. If you choose to use a provider who is not on the PPO list, your out-of-pocket expenses will be higher than if you use a provider who is on the list.

- **Point of Service Plans**. These plans combine features of the HMO and PPO. They allow members to use services provided outside of the network without prior approval from a network doctor. Point of service plans offer lower deductibles and no coinsurance for visits to doctors *inside* the network. Visits *outside* the network normally require the payment of deductibles and coinsurance the same as a traditional fee-for-service insurance policy.

Fee-for-Service Plans pay for each service as it is rendered according to a set fee schedule. The insurer pays for each service rendered upon receipt of a claim form and bill which indicates the charge.

When you subscribe to a fee-for-service plan you are not required to have a primary care physician (PCP). You can seek services from any provider without a referral and the carrier will pay the agreed upon fee.

BEFORE YOU BUY HEALTH COVERAGE ...

find out about the company selling the plan. Here are factors to consider:

- **Customer Service.** Find out how the company services its policyholders. Does the company have a toll-free customer service number?

- **Complaint History.** Has the company had an unusually high number of consumer complaints?

- **Licensing Status.** Call the Insurance Department to find out if the insurance company and its sales staff are licensed to do business in Delaware.

- **Cost.** Premiums for health insurance will vary greatly because there are no standard plans. When you look at bids from several companies, you will also need to look carefully at the benefits offered. Also, keep in mind that the actual cost for your health coverage will be determined after you submit information about your health.

- **Financial Stability.** Financial stability helps ensure that a company can pay its claims. The Insurance Department establishes requirements that each company must follow and

continually monitor the financial stability of insurance companies operating in Delaware. Call the Department to find out if a particular company is in good standing. Independent organizations, such as AM Best and Standard & Poor, also rate the financial stability of insurance companies. Remember, these ratings are opinions only and do not guarantee that a company is financially sound. Most Delaware public libraries have published ratings from these sources.

QUESTIONS TO ASK WHEN SHOPPING FOR HEALTH CARE

About Coverage

- What does the plan pay for?
- What does the plan not pay for?
- What, if any, exclusions exist?
- What are the limits on pre-existing medical conditions?
- Will the plan pay for preventive care, immunizations, well-baby care, substance abuse, organ transplants, vision care, dental care, infertility treatment, durable medical equipment, or chiropractic care?
- Will the plan pay for prescriptions?
- Does the plan have mental health benefits?
- Will the plan pay for long-term physical therapy?

About Premiums

- Do rates increase as you age?
- How often can rates be changed?

About Out-of-Pocket Expenses

- How much do you have to pay when you receive health care services (copayments and deductibles)?
- Are there any limits on how much you must pay for health care services you receive (out-of-pocket maximums)?
- Are there any limits on the number of times you may receive a service (lifetime maximums or annual benefit caps)?

About Customer Service

- Has the company had an unusually high number of consumer complaints?
- What happens when you call the company's consumer complaint number?
- How long does it take to reach a real person?

HOW TO MAKE A HEALTH INSURANCE CLAIM OR DISPUTE DENIALS

Things to do *before* you file a claim:

- Review your policy or employee booklet carefully to be sure the service in question is covered.
- Follow any managed care rules, including pre-certification requirements and use of network providers.
- Give claim forms to the provider, with your policy number and other identifying information.

How to submit a claim properly:

- Find out if your provider submits the claim for you or if you need to do it.
- If you need to do it, review the information to be sure it is complete and correct.
- File it as soon as you get the bill from the provider.
- Send it to the right address.
- Keep a copy for your reference.

Allow reasonable time for the company to process your claim. Delaware's PROMPT PAYMENT Regulation requires the company to pay a claim within 45 days, unless it needs any additional information to complete the claim. Sometimes, it will request additional information directly from the providers or return the claim form to you to get more information. If the company needs additional information it has to tell you so within 30 days. After the company has all the information it needs, it has 45 calendar days to process your claim. The company must send you an explanation of benefits that explains its decision.

If your claim is paid:

- If you assigned benefits to the provider, the benefit check will be sent directly to the provider.
- You will pay any deductibles and co-insurance.
- If you did not assign the benefits, the check will come to you and you will need to pay your provider for the entire amount.

If your claim is denied:

- The reason for denial should be stated on your explanation of benefits.
- If you disagree with the basis stated for denial, check your policy or employee booklet for the company's appeal procedures.
- The company should be able to answer procedural questions about appeals over the phone.
- Your appeal should be in writing and may require information from your doctor.

Filing a complaint with the Insurance Department:

If after going through the company's appeal process you feel that your claim was unfairly denied, contact the Insurance Department's Consumer Service Division. Very often, companies will resolve disputes after a Consumer Services Representative intervenes on the consumer's behalf. Getting help is quick and easy, all you need to do is pick up the phone.

If your company insists your complaint or claim is not valid, the Insurance Department cannot require the company to make a payment unless state insurance law has been violated. You may want to consult a lawyer if your complaint cannot be resolved or choose the Insurance Department's **arbitration** program as a low-cost alternative to litigation.

WHAT IF YOUR PLAN IS NOT REGULATED BY THE STATE OF DELAWARE?

Many large employers (more than 50 employees) in Delaware are self-funded. They do not buy health insurance from an insurance company but use employee contributions and company funds to provide health care benefits for employees.

The Insurance Department is not permitted to regulate most self-funded plans. This means: (1) The Insurance Department has no authority to investigate complaints that involve valid single-employer or union-sponsored self-funded ERISA plans; (2) certain other group health plans provided by governments, churches, some school districts and out-of-state Blue Cross organizations also are exempt from Delaware regulations; and (3) Delaware laws requiring specific benefits in health care plans seldom apply to valid self-funded ERISA plans.

The designated regulatory authority is the US Department of Labor, Pension & Welfare Benefits Administration. If you have a problem with your self-insured plan, contact the following:

1st The Plan Administrator
2nd Your Employee Benefits Counselor at work
3rd Your Union Representative
4th The U.S. Department of Labor, Pension & Welfare Benefits Administration
(202) 219-8776
5th Your Private Attorney

DELAWARE INSURANCE DEPARTMENT
841 Silver Lake Boulevard
Dover, Delaware 19904

CONSUMER HOTLINE 1-800-282-8611
COMPANY LICENSING 1-302-739-5774
AGENT LICENSING 1-302-739-4254
ELDER*info* 1-800-336-9500